ACO Project Overview and Key Elements

Presented to FSSA

September 3, 2013

Franciscan ALLIANCE
Accountable Care Organization

Background of Presentation

House Enrolled Act 1328 requires the Indiana Family and Social Services Administration (FSSA) to prepare a report on Medicaid managed care for the blind, aged, and disabled Medicaid population for the legislative Health Finance Committee by December 15, 2013. The report is to review three approaches:

- Risk-based capitated managed care
- Managed fee-for-service
- Home and community based services management program

Franciscan Alliance ACO

Franciscan Alliance is a physician-hospital based organization:

- It acts as the single agent for managed care contracting, presenting a united front to payers.
- The Alliance provides administrative services, credentials physicians , monitors utilization, as well as, promotes preventive and wellness quality initiatives.
- Franciscan Alliance includes capitated and managed fee-for-service lives.

Franciscan Alliance managed lives

- In addition to those served by our facility and provider offices, our infrastructure has allowed us to improve the quality of lives and reduce cost for thousands of "managed" persons.

Covered Lives and ACO Beneficiaries as of 08/27/13	
HHW (capitated membership only)	33,116
HIP (capitated membership only)	241
Commercial (Fran=6000, Adv=8,000)	29,838
Pioneer ACO (NIR=7300, CIR=20,000)	27,288
AHN	26,929
Union	15,061
Cigna	3,764
Total	**136,237**

Models for consideration for the ABD population

Franciscan Alliance presents their Accountable Care Organization (ACO) model of care for consideration for the ABD population or a subset thereof.

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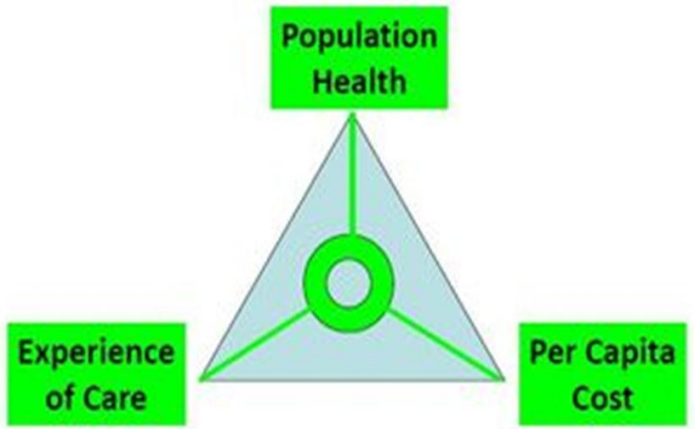
What is an Accountable Care Organization?

An Accountable Care Organization, or ACO, is an entity that agrees to be accountable for the quality, cost, and overall care of a defined population

The Goal of an ACO: Achieve the "Triple Aim"

1. Better population health
2. Higher-quality care
3. Lower costs of care



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How do ACO's help achieve the "Triple Aim"?

- ACO's focus on better healthcare via efforts to improve quality and reduce costs across the care continuum:
  - Care coordination
  - Reduced waste
  - Process improvement
  - Informed patients
  - Disease management
  - Point of care reminders and best-practices
  - Actionable, timely data
  - Partnerships across the continuum

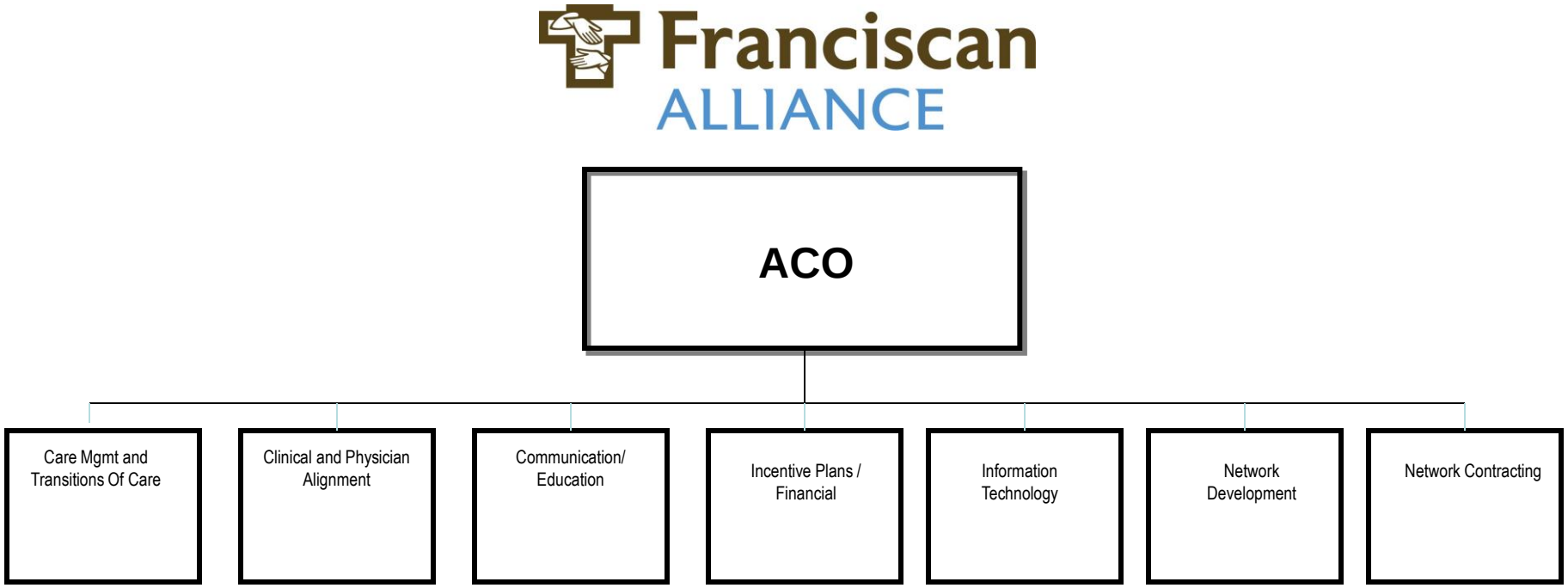
Leaders in a Changing Landscape

We must work to transition our care model to meet the goals of accountable care

Development of an effective ACO requires:

1. **A new way of thinking**: *system* performance vs. *site* performance.
2. **Development of a system-wide strategy to optimize resources**.
3. **"Team-based"** planning approach

Why ACO's


Franciscan ALLIANCE
ACO
Care Mgmt and Transitions Of Care
Clinical and Physician Alignment
Communication/ Education
Incentive Plans / Financial
Information Technology
Network Development
Network Contracting

ACO Care Coordination Partnerships

Franciscan Alliance has strategically developed a multitude of partnerships for the success of the ACO, including:

- Post Acute Continuing (PAC) Care Network
- Renal Care Network
- Behavior Health Network
- CICOA
- ADVANTAGE
- WINDROSE Health Network (FQHC)
- Readmission Team
- Telemonitoring Team
- Home Coaching Team
- CVS Partnership (Poly-pharmacy and Generic Use)
- YMCA Diabetic Prevention
- CDC – Fall Risk Assessment

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ACO Key Elements

COMPLEX CARE COORDINATION AND DISEASE MANAGEMENT

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ACO Care Coordination

- **General Programs:** Complex Care Coordination (CCC) and Disease Management (DM)
- **Continuing Care Networks:** Post-Acute Transitional Care, Renal (End-Stage) Care, and Behavioral Health
- **Decision Support:** Evidenced-Based Practice Guidelines / Predictive Modeling
- **Chronic Disease Primary Foci:** Heart Failure (HF), Chronic Obstructive Pulmonary Disease (COPD), Diabetes (DM), and Coronary Artery Disease (CAD)
- **Care Delivery Model** includes Advance Practice Nurses (APN), which include Clinical Nurse Specialists (CNS) and Nurse Practitioners (NP), Social Workers (SW), and Registered Nurses (RNs)

Beneficiary Selection for CCC and DM

- Provider referral
- Predictive modeling scores (based on claims data and health risk assessment)
- Number of chronic conditions
- Inpatient stay
- Post-acute setting transition
- Readmission
- Emergency department utilization
- Registries and Population Health Management
- Urgent or immediate care utilization
- High dollar claims
- Quality gaps in care

Disease Management Stratification Process

- Four tiered stratification: Levels 1 – 4
- Disease Management is provided for Level 1 and Level 2 (low risk of non-adherence with evidence-based clinical practice guidelines) for beneficiaries with migraines, asthma, and hypertension. Interventions include:
  - Telephonic outreach/mailings/self management tools conducted by health coach/coordinator
  - Use of evidenced based educational material

Disease Management Stratification Process

- ACO RNs and SWs provide DM for Level 3 and Level 4 (all diagnoses): High risk for non-adherence with clinical practice guidelines
    - Referrals to Complex Care Coordination when needed
    - Motivational Interviewing for behavioral change
    - May receive home visits
    - Link to community resources

ACO Care Coordination

- Case selection:
- Pre-assessment process (diagnosis/degree of adherence and self management/care gaps)
- Beneficiary consent (participation is voluntary)
- Assessment (assigns acuity based on needs):
  - Level 1= <1 hr/month
  - Level 2= > 1 hrs but < 3 hrs/month
  - Level 3= > 3 hrs but <5 hrs/month
  - Level 4= > 5 hrs /month

ACO Care Coordination

- Planning/Coordination (multidisciplinary outreach/collaborative plan of care/education/referrals for home care, social services, etc.)
- Monitoring/Evaluation (reassess needs/revises care plan
- Advocacy (coordination of care, continuity of care, self-advocacy)

Complex Care Coordinators

- RNs with Case Management experience
- Social Workers
- Nurse Practitioners
- Clinical Nurse Specialists
- May visit beneficiary in the hospital/home setting
- May accompany beneficiary on doctor visits
- Serves as consistent health care resource throughout the care continuum

ACO Quality Measures (HEDIS and HEDIS-LIKE)

•ACO 1-7: CAHP Surveys	•ACO 22 DM pts with HgA1c < 8
•ACO 8: 30 day Readmissions	•ACO 23 DM pts with LDL < 100
•ACO 9: Ambulatory Care Sensitive Condition (ACSD) Asthma, COPD with Admission	•ACO 24 DM pts with BP> 140/90
•ACO 10: ACSC of CHF w/ Admission	•ACO 25 DM pts that are non-smoker
•ACO 11: % of PCP's with MU EMRs	•ACO 26 DM pts using Aspirin
•ACO 12 Medication Recon after D/C	•ACO 27 DM pts with HgA1c> 9
•ACO 13 Fall Risk Assessment	–(lower is better)
•ACO 14 Influenza Vaccination	•ACO 28 HTN pts with BP < 140/90
•ACO 15 Pneumococcal Vaccination	•ACO 29 IVD pts with LDL < 100
•ACO 16 Adult BMI, and f/u if >30	•ACO 30 IVD pt on Aspirin or
•ACO 17 Tobacco Cessation	Other anti-thrombotic
•ACO 18 Depression Screening	•ACO 31 CHF pt on Beta Blocker
•ACO 19 Colorectal Screening	•ACO 32 Pt with CAD with LDL <100
•ACO 20 Mammogram Screening	•ACO 33 Pt with (CAD and DM) or (CAD and CHF) on an ACE or ARB
•ACO 21 Blood Pressure Screening	

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IT/DATA EXCHANGE PLATFORM

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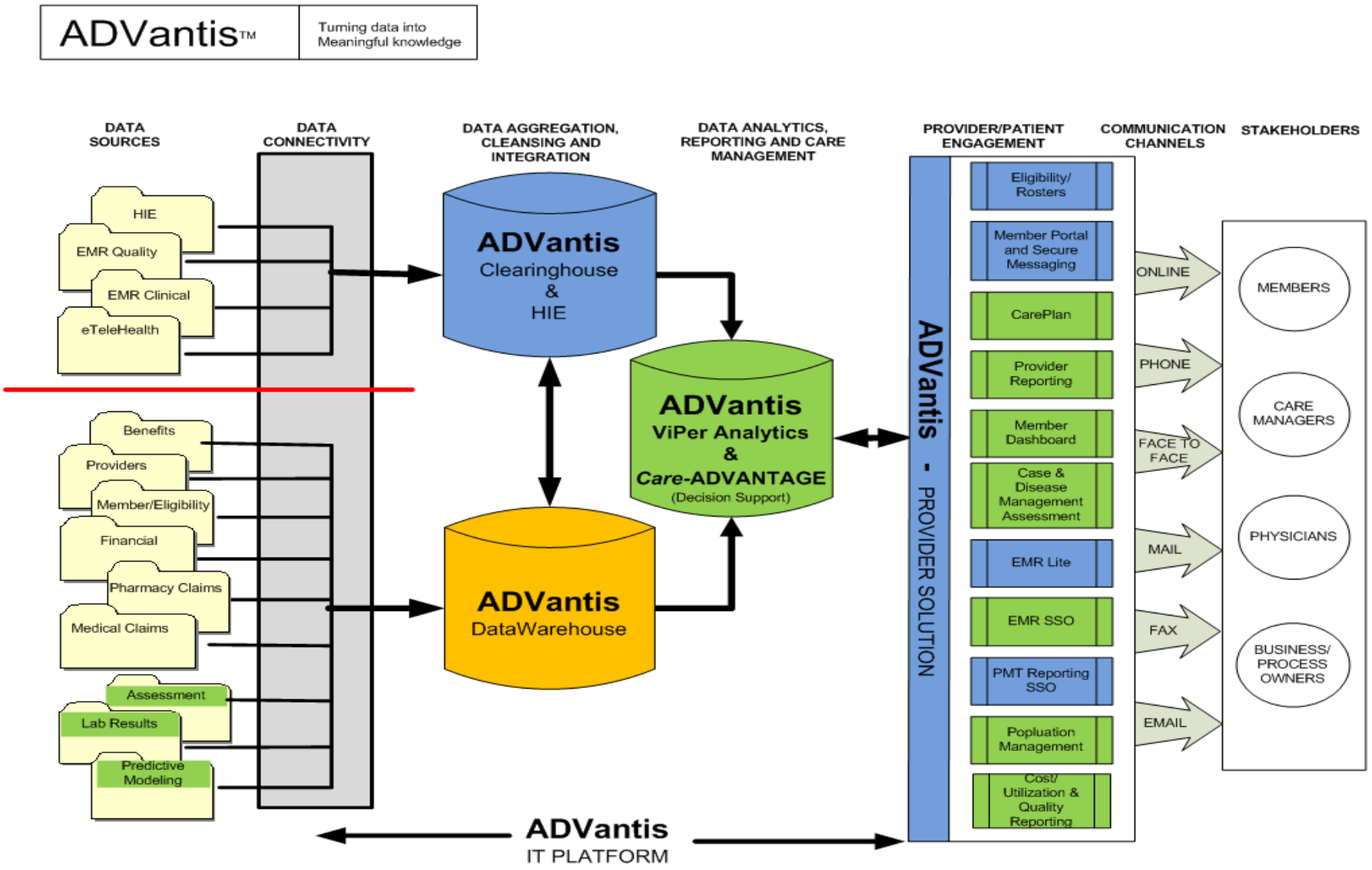
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COMMUNICATION CHANNELS
STAKEHOLDERS
HIE
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Thank You

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